MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

07047

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Hanford
City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Herbert Berg.

3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 16, 1870

8. AGE: Years: 76 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Sweden (Town, county, and state)

10. Usual occupation: Farm labor

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs. Ernst Breeden
Address: Fallston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/22/46 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Fallston, Md.

18. Funeral director: Chas. E. Goos
Address: Benson Md

19. 7/22 1946 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20 1946, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to 7/20 1946
and that I last saw him alive on July 20 1946

	DURATION
Immediate cause of death Chronic Cardio renal disease & acute uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P M Hopkins M. D. or other
Address Bel Air Md Date signed 7/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

O.L
96
1946

07048

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Fountain Green Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lucy H Bowman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: C E Bowman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1861

8. AGE: Years 84 | Months 10 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: at Home

FATHER
12. Name: Geo. H. Gorrell
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Charlotte Rivon
15. Birthplace: Harford Co., Md.

16. Informant: Mr. Lonnie Bowman
Address: Aberdeen Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/27/46 (month) (day) (year)
Cemetery or crematory: Rock Run Cem
Location: Hartford Md.

18. Funeral director: H S Bailey
Address: Darlington

19. 7/25 19 46 (Date rec'd by registrar) Priscilla Tourard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 19 46, at 8:24 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1- 19 46 to July 24 19 46
and that I last saw her alive on July 23 19 46

Immediate cause of death	DURATION
Hypostatic Pneumonia	5 da
Due to Terminating	
a Chr. Myocardial Disease	1½ yr
Due to	
Other conditions Gen. Arteriosclerosis ?	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md. Date signed 7/24/46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07049 Reg. Dist. No. 181

1. PLACE OF DEATH:

County HARFORD

City or town CHURCHVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Rural Aberdeen R.D. #2

(If outside city or town limits, write RURAL and give nearest town)

Street No. Churchville

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME JOHN H BRAGG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 - 1903

8. AGE: Years	Months	Days	If less than one day
42	11		hrs. min.

9. Birthplace Bluefield W. Va (Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business Log Canning house

FATHER 12. Name John H. Bragg

13. Birthplace Bluefield W. Va

MOTHER 14. Maiden name Osa Hall

15. Birthplace Bluefield W. Va

16. Informant Mrs. John H. Bragg

Address Aberdeen Md. R.F.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13 - 1946 (month) (day) (year)

Cemetery or crematory Smith Chapel

Location Churchville Harford Co.

18. Funeral director Henry Fanning Adams

Address Aberdeen Md.

19. July 12 1946 Nellie F. Riley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1946 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Hemorrhage	
Due to Pulmonary Tuberculosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Lamon M.D.
DEP. MED. EXAMINER
M.D. or other

Address Aberdeen, Md. Date signed July 13 1946

CITIES OR CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

07050

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hr.

Hospital, institution, or street address where death occurred:
Harford Memorial Hosp

How long in hospital or institution? 10 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Baby Boy Coale

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years | Months | Days | If less than one day: 10 hrs. min.

9. Birthplace: Havre de Grace, Harford Co., Md
(Town, county, and state)

10. Usual occupation: Newborn

11. Industry or business:

FATHER
12. Name: Charles W. Coale
13. Birthplace: Maryland

MOTHER
14. Maiden name: Marie Jamison
15. Birthplace: Maryland

16. Informant: Charles W. Coale
Address: Bel Air Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20, 1946 (month) (day) (year)
Cemetery or crematory: St Stephens
Location: Bradshaw Md

18. Funeral director: Howard K. McComas
Address: Abingdon Md

19. July 23 1946 (Date rec'd by registrar) G. L. Lewis No. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1946 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1946 to July 18 1946 and that I last saw h... alive on July 18 1946

Immediate cause of death	DURATION
Prematurity	10 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dudley Phillips Md M. D. or other
Address: Harford Mem. Hosp Date signed 7/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07051

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

Harford Mem. Hosp.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Perryman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Benjamin Barnes Cooper

3.(b) Social Security Number 218-14-4907

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5 - 1891

8. AGE: Years 65 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Harford Co. Md (town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Edward I Cooper

13. Birthplace Harford Co. Md.

MOTHER 14. Maiden name Susan Boyce

15. Birthplace Harford Co. Md.

16. Informant Mrs. William E. Cooper

Address Perryman Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13-1946 (month) (day) (year)

Cemetery or crematory Cokesbury

Location Churchville, Harford Co.

18. Funeral director Henry Tanzey Sons

Address Aberdeen Md.

19. 7-12 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1946 to July 10 1946 and that I last saw h[illegible] alive on July 20 1946

	DURATION
Immediate cause of death Cerebral Hemmorhage	12 hrs
Due to Hypertension	
Due to	
Other conditions Congestive Heart Failure	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dudley Shelby M.D. M. D. or other

Address Harford Mem. Hosp. Date signed 8/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

07052

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen Proving Ground, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County:
City or town: Columbus
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John D. Cunningham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 17 June 1928

8. AGE: Years	Months	Days	If less than one day
18	1	11	hrs. min.

9. Birthplace: Columbus, Ohio (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Josephine (Unknown)
15. Birthplace: Alabama

16. Informant: U.S. Army Records
Address: Aberdeen Proving Ground Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof July 30 1946 (month) (day) (year)
Cemetery or crematory: D.A. Whittaker & Sons
Location: 720 E. Long St., Columbus, O.

18. Funeral director: Howard K. McComas & Son
Address: Abingdon Maryland

19. Aug 1 1946 Nellie H Riley
(Date rec'd by registrar) Registrar

I certify that I have received the remains of the above in good condition

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 July 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DOA 19 to 19
and that I last saw h alive on DOA 19

Immediate cause of death	DURATION
Drowning, accidental	
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

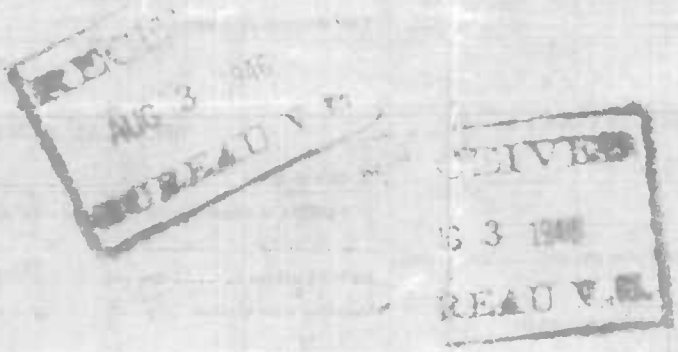
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph L Bird Capt M.C.
M. D. or other
Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07053

Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: May S C Ewing

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Harvey Ewing

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 7 - 1880

8. AGE: Years: 66 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Churchville, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: James B Stewart

13. Birthplace: Md

MOTHER 14. Maiden name: Mary Elizabeth Coale

15. Birthplace: Churchville, Md.

16. Informant: John S Carver

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 / 46 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Fountain Green

18. Funeral director: Dean & Sutton

Address: Bel Air Md

19. 7/2 (Date rec'd by registrar) 46 Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1946 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 1946 to 1 July 1946 and that I last saw her alive on 1 July 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: -	
Due to: -	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles Richardson Jr. M.D. M. D. or other

Address: Bel Air, Md Date signed 2 July 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 070518 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Carsins Run
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Bennett Wade Gilbert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary M. Schantz

6.(c) If alive, give age: 61 yrs years

7. Birth date of deceased (mo., day, yr.): August 22, 1893

8. AGE: Years	Months	Days	If less than one day
52	10		hrs. min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Benjamin Gilbert
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Catherine Savard
15. Birthplace: Balto. Co. Md.

16. Informant: Mrs B. Wade Gilbert
Address: Aberdeen - R.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 1946 (month) (day) (year)

Cemetery or crematory: Bakers

Location: Aberdeen Md.

18. Funeral director: Henry Jarrings & Sons

Address: Aberdeen Md

19. July 3 1946 Nellie L. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1946, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 7 1945, to July 2 1946 and that I last saw him alive on June 10 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. E. Gallion M. D. or other

Address: Darlington Date signed: 7/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07055

Reg. Diat. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harf Co.
City or town: Aberdeen Proving Ground Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Aberdeen Proving Ground Station Hosp.
How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Georgia County:
City or town: Iron City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hall, Eldridge E.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1926

8. AGE: Years	Months	Days	If less than one day
19	7	13	...hrs. ...min.

9. Birthplace: Lakeland, Fla. (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U.S.A.

FATHER
12. Name: Brooks Hall
13. Birthplace: ~~Miller~~ Early County, Georgia

MOTHER
14. Maiden name: Evie Hall
15. Birthplace: Miller County, Georgia

16. Informant: mother
Address: ~~Donalds~~ Iron City, Georgia

17. Interment (Burial, cremation, or removal. Which?) Date thereof July 26, 1946 (month) (day) (year)
Cemetery or crematory: R.E. Evans
Location: Donaldsonville Ga.
18. Funeral director: R. E. Evans H. McInnis Sons
Address: Donaldsonville, Ga. Abingdon Md.
19. July 29 1946 (Date rec'd by registrar) Nellie A. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 July 1946 at 3:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 July 1946 to death 19...
and that I last saw him alive on 25 July 1946

Immediate cause of death	DURATION
Respiratory Failure, Central type.	
Due to: Bacteremia, type undetermined	
Secondary to pharyngitis +	
Due to: Conjunctivitis, Cause undetermined.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Myocardial necrosis; pulmonary edema Hepato-splenomegaly; pleural effusion
Autopsy results: Ecchymoses - ankles, shoulders, pericardial
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Gibson L. Buchanan M. D. ~~or other~~
Address: Aberdeen Proving Grd Md. Date signed 1st M.C. July 25 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

07056

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Jarrettsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Jarrettsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Sallie Jarrett Hamilton

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: C. Norman Hamilton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15 1876

8. AGE: Years: 70 | Months: 1 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Jarrettsville Harford Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Wm B Jarrett

FATHER — 13. Birthplace: Jarrettsville Md

MOTHER — 14. Maiden name: Mary V. Carnes

MOTHER — 15. Birthplace: Jarrettsville Md

16. Informant: Mrs Allen St Clair

Address: Rock Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 23 1946 (month) (day) (year)

Cemetery or crematory: Jarrettsville

Location: Jarrettsville Harford Co Md

18. Funeral director: Martin S Kurtz

Address: Jarrettsville Md

19. July 23 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1946, at 7.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1944, to July 1946

and that I last saw h. C.T. alive on July 20, 1946

Immediate cause of death	DURATION
Metastatic uterine carcinoma	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Uterine carcinoma

Date of op. May 10, 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles A. Duff, M. D. or other

Address: Street, Md. Date signed 7-21-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-0)

CERTIFICATE OF DEATH

07057

Reg. Dist. No. 185

• THIS DOCUMENT IS LIMITED BY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 10 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Baby Harris

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) July 24 - 1946

6.(c) If alive, give age ..... years

8. AGE: Years +0 | Months | Days | If less than one day: 10 hrs. ..... min.

9. Birthplace Havre de Grace, Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business Baby

FATHER
12. Name Robt Harris
13. Birthplace

MOTHER
14. Maiden name Marie Hawkins
15. Birthplace Havre de Grace Md

16. Informant Hospital Record
Address Havre de Grace Md

17. Burial (Burial, cremation, or removal) Date thereof July 27, 1946 (month) (day) (year)
Cemetery or crematory Shawnee
Location Havre de Grace Md

16. Funeral director Elmer E. Bullock
Address Havre de Grace, Md

19. July 26 1946 C. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1946 to July 26 1946 and that I last saw h— alive on July 26 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 hr
Due to Prolonged labor	
Due to Cephalo pelvic disproportion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dudley Shellin M.D.
M.D. or other
Address Harford Mem. Hosp. Date signed 7/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

07058

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Harford
City or town: Bel-Air (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Convalescent Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel-Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William James Hawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known 1859

8. AGE: Years	Months	Days	If less than one day
87	—	—	hrs. min.

9. Birthplace: Jarrettsville Har. Co. (Town, county, and state)
10. Usual occupation: Caretaker & Farmer
11. Industry or business
FATHER 12. Name: Wm Nelson Hawkins
13. Birthplace: Va.
MOTHER 14. Maiden name: Sarah Wood
15. Birthplace: Jarrettsville, Har. Co.
16. Informant: Mrs. Maurice Royston
Address: 1021 W. 38th St. Balto. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13, 1946 (month) (day) (year)
Cemetery or crematory: Slate Ridge
Location: Delta, Pa.
18. Funeral director: Martin B. Kurtz
Address: Jarrettsville, Md.
19. 7/12/46 (Date rec'd by registrar) Priscilla Fawwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1946, at 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1946 to 1946
and that I last saw him alive on July 10 1946

Immediate cause of death	DURATION
Probably - cerebral hemorrhage	
Due to: Age —	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

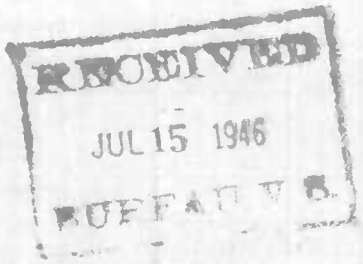
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C B Hopkins M. D. or other
Address Bel Air Md Date signed 7/12/46

1946
1819

87

Dec 2



WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

07059 85-
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 Weber
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elmer Houck

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Myrtle D. Houck
6.(c) If alive, give age ! years

7. Birth date of deceased (mo., day, yr.) August 8, 1881

8. AGE: Years	Months	Days	If less than one day
64	11	20	...hrs. ...min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business
FATHER 12. Name George W. Houck
13. Birthplace Baltimore
MOTHER 14. Maiden name Fannie Rhine
15. Birthplace Baltimore
16. Informant Mrs. Myrtle D. Houck (wife)
Address 103 Weber St
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 1, 1946 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace Md.
19. July 31 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1946 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1 1946 to 7/29 1946 and that I last saw h. alive on 7/29 1946.

	DURATION
Immediate cause of death Arteriosclerosis	
Hypertension	
Due to Coronary Thrombosis	
Due to Angina Pectoris	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. M. D. or other
Address Havre de Grace Md. Date signed 7/31/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

07060

Reg. Diat. No. 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air, Md

(If outside city or town limits, write RURAL and give nearest to

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William T. Joines

3. (b) Social Security Numb 220-09-3196

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 19 - 1889

8. AGE: Years 57 | Months | Days | If less than one day hrs. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual occupation Wood Finisher (Floors)

11. Industry or business

FATHER 12. Name John P Joines

13. Birthplace N. C.

MOTHER 14. Maiden name Susan Edwards

15. Birthplace N. C.

16. Informant Mrs Gertrude Choate

Address Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 46 (month) (day) (year)

Cemetery or crematory Fair View (Baptist)

Location Near Churchville, Harford Co, Md

18. Funeral director Deaver Foster

Address Bel Air Md

19. 7/11 19 46 Priscilla Fawood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 6:25P

20. DATE OF DEATH July 8 19 46 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased fr

July 8 19 46, to July 8, 1946

and that I last saw him alive on July 8, 1946

Immediate cause of death Cerebral Hemorrhage

(onset 7/6/46)

Due to

Due to

Other conditions Chronic Myocardial disease with decompensation. 1 year

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statisti

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (Sta

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Hedges (M. D. or oth

Address Forest Hill Md 7/9/46 Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07061

Reg. Diat. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Street, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Street
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: James C. Kelley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 10 - 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	5	5		

9. Birthplace: Thomases Run, Md (Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business: Electrical wiring
FATHER 12. Name: Robert A. Kelley
FATHER 13. Birthplace: Cecil, Co - Md
MOTHER 14. Maiden name: Annie Carrol
MOTHER 15. Birthplace: Pa.
16. Informant: Mrs Phebe Morris
Address: Street
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1946 (month) (day) (year)
Cemetery or crematory: Darlington, Md
Location: Darlington, Md
18. Funeral director: H. C. Bailey
Address: Darlington, Md
19. Aug. 12 1946 (Date rec'd by registrar) M. W. Tirla Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1946, at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... last saw him ... arrived ... and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
cardiac angina	1 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: ns

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. E. Galbiot M. D. or other
Address: Darlington, Date signed 7-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07062

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph C Mast

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Ada D. Madron Mast

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8, 1869

8. AGE: Years: 77 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Joseph H. Mast

FATHER — 13. Birthplace: N.C

MOTHER — 14. Maiden name: Clarissa Moore

MOTHER — 15. Birthplace: N.C

16. Informant: Mrs Ada M Mast

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 17 / 46 (month) (day) (year)

Cemetery or crematory: Mast Cemetery

Location: Abingdon Va

18. Funeral director: Deaver Foster

Address: Belair Md

19. 7/15/46 (Date rec'd by registrar) Priscilla Fawwood, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 19 46 at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 46 to July 14 19 46 and that I last saw him alive on July 14 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	3½ da.
Due to: Essential Hypertension	10 yrs
Due to:	
Other conditions: 2 Previous Cerebral Hemorrhages.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willard R. Hudson, M. D. or other

Address: Forest Hill, Md Date signed: 7/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

07063

Reg. Diat. No. 182

1. PLACE OF DEATH:

County: Harford Co

City or town: Forest Hill, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford Co

City or town: Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William H Presbury

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	W

6.(b) Name of husband or wife: Mary F Jackson

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): April 22 / 1869

8. AGE:

Years	Months	Days	If less than one day
77	4		hrs. min.

9. Birthplace: Harford Co (Town, county, and state)

10. Usual occupation: Cemetery Care Taker

11. Industry or business

FATHER

12. Name: Wm H Presbury

13. Birthplace: Harford Co., Md

MOTHER

14. Maiden name: UNKNOWN

15. Birthplace: UNKNOWN

16. Informant: Marshall Presbury

Address: Forest Hill

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25/46 (month) (day) (year)

Cemetery or crematory: Fair View

Location: aboun Forest Hill, Md

18. Funeral director: Dean & Foster

Address: Bel Air, Md.

19. 7/23 (Date rec'd by registrar) 1946 Priscilla Fowood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1946, at 6 10 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from APRIL 19 1946, to JULY 20 1946

and that I last saw him alive on JULY 20, 1946

Immediate cause of death	DURATION
CEREBRAL THROMBOSIS	3 WEEKS
Due to: ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	2 YEARS
Due to:	
Other conditions: SENILITY	
CONGESTIVE HEART FAILURE	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE

Date of op. —

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert A Barthel MD (M. D. or other)

Address: Forest Hill, Maryland Date signed: 7/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

07064 82

Reg. Diat. No. 184

1. PLACE OF DEATH

County: Harford

City or town: Rural - Darlington, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Darlington RFD #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION) No

2.(a) If veteran, name war

3.(a) FULL NAME

JACK Broudfit ~~Broudfoot~~

3.(b) Social Security Number

No

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6.(b) Name of husband or wife: No

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 9 1931

8. AGE:	Years	Months	Days	If less than one day
	15	4	24	hrs. min.

9. Birthplace: ~~Laboard~~ West Moreland Co Pa
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: John Broudfit
13. Birthplace: Allegheny Co, Pa.

MOTHER
14. Maiden name: Lillian Saunders
15. Birthplace: Allegheny Co, Pa

16. Informant: John Broudfit
Address: Darlington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2 1946 (month) (day) (year)

Cemetery or ~~Crematory~~: Darlington Cem

Location: Harford Co., Md

18. Funeral director: H. S. Bailey

Address: Darlington, Md.

19. August 1 1946 M. A. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1946 at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
FRACTURE OF SKULL	
Due to: CRUSHING INJURY OF HEAD AND FACE	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE

Date of op.

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ACCIDENT Date of: July 30, 1946

Where did injury occur? NEAR DARLINGTON HARFORD MD.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) FARM

Means of injury: TRACTOR FELL OVER WHEN Injured at work? YES

23. SIGNATURE: James H Ramey M.D.
DEP. MED. EXAMINER / M. D. or other

Address: Aberdeen, Md. Date signed: July 30, 1946

VS-A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

CITIES OR CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH ★

07065

Reg. Dist. No. 185-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 day
Hospital, institution, or street address where death occurred:
Harford Mem. Hosp
How long in hospital or institution? 3 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Race Track
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MARY D. Ross

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband ~~or wife~~ James P. Ross
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 31, 1886

8. AGE: Years	Months	Days	If less than one day
69	3	10	..... hrs. ..... min.

9. Birthplace Lexington Kentucky
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Thomas Donlan
13. Birthplace Ireland
MOTHER 14. Maiden name Sarah Lavin
15. Birthplace Ireland
16. Informant James P. Ross
Address Havre de Grace Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/14/46 (month) (day) (year)
Cemetery or ~~crematory~~ Calvary
Location Lexington Kentucky
18. Funeral director Pennington & Son
Address Havre de Grace, Md.
19. July 11 1946 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1946 at 4:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1946 to July 11 1946
and that I last saw h... alive on July 11 1946

Immediate cause of death	DURATION
Cerebral Hemmorhage	12h
Due to Pelvic Thrombosis & Hypertension	
Due to	
Other conditions Duct Hepatitis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dudley Shelby MD M. D. or other
Address Harford Mem. Hosp Date signed 7/11/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-f) X

07066 D ?

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Richard

City or town Rural - Sweet

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford Co.

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. near Abingdon

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Theodore C. H. Schneider

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Edith W. Schneider

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19, 1871

8. AGE: Years	Months	Days	If less than one day
75	3	17	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Photographer

11. Industry or business .....

FATHER 12. Name August Schneider

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Louise Meshyer

MOTHER 15. Birthplace Germany

16. Informant Mrs. Redding

Address Sweet

17. Burial Date thereof July 10, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore

18. Funeral director Rita Wiedefeld

Address 900 E. Biddle St

19. 7-9-46 19..... Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1946, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 44, to July 6 1946

and that I last saw him alive on July 3 1946

Immediate cause of death Carcinoma neck and throat (Primary)

DURATION
.....
.....
.....
.....
.....
.....

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. H. Schneider M. D. or other

Address Bel Air Md Date signed 7/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07067 182

Reg. Dist. No. ~~189~~

1. PLACE OF DEATH:
County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME Eugene C. Deagle

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of husband or wife: Montana Deagle alive 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 24, 1887

8. AGE: Years	Months	Days	If less than one day
58	7	2	hrs. min.

9. Birthplace: Wythe Co., Va. (Town, county, and state)
10. Usual occupation: Orchardist
11. Industry or business
12. Name of FATHER: Walter S. Deagle
13. Birthplace of FATHER: Wythe Co. Va.
14. Maiden name of MOTHER: Elmira D'vale
15. Birthplace of MOTHER: Wythe Co Va
16. Informant: Mrs. E. C. Deagle
Address: Darlington Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29, 1946 (month) (day) (year)
Cemetery or crematory: Centre Cem
Location: Harford Co., Md.
18. Funeral director: H. L. Bailey
Address: Darlington, Md.
19. July 27 1946 M. A. Clark
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1946 at 11.4 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1946 to July 26 1946
and that I last saw h... alive on July 26 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs
Due to: Arterio Sclerosis	2 yrs
Due to: ~	
Other conditions: ~	

(Include pregnancy within 3 months of death)

Major findings of operations: ~ Date of op.
Autopsy results: ~
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. P. Snodgrass M. D. or other
Address: Darlington Md Date signed 7/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

IF IN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

07068

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hr
Hospital, institution, or street address where death occurred:
Harford Mem. Hosp.
How long in hospital or institution? 24 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Sadie Smith

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widow

6.(b) Name of husband ~~or wife~~: Willie Smith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 15, 1886

8. AGE: Years	Months	Days	If less than one day
60		5	..... hrs. ..... min.

9. Birthplace Aberdeen, Harford Co., Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name George Treby
FATHER 13. Birthplace Aberdeen Md.
MOTHER 14. Maiden name HARRIET Green
MOTHER 15. Birthplace Md
16. Informant Kate Williams. Address Aberdeen, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23 1946 (month) (day) (year)
Cemetery or crematory Union M. E. Cemetery
Location Near Aberdeen
18. Funeral director Henry Tarring & Sons Address Aberdeen, Md.
19. July 22 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1946 at 8:10 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1946 to July 19 1946 and that I last saw h[illegible] alive on July 19 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Dudley Shallcross M.D. M. D. or other
Address Harford Memorial Hosp. Date signed 7/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07069

Reg. Dist. No. 18S-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 7 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 Goods Court
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Ida Stansbury

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Married

6.(b) Name of husband or wife: Charles Stansbury
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Dec 24 - 1884

8. AGE: Years	Months	Days	If less than one day
61	6		hrs. min.

9. Birthplace: Pennsylvania Harford Co. Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William Chesley
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Martha Chesley
15. Birthplace: Harford Co. Md.

16. Informant: Mrs. Florence Johnson
Address: #5 Goods Court Havre de Grace Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 - 1946 (month) (day) (year)
Cemetery or crematory: Union M. E.
Location: Near Aberdeen Md
18. Funeral director: Perry Fanning Sons
Address: Aberdeen Md.

19. July 9 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/8 1946 at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1946 to July 8 1946 and that I last saw her alive on July 8 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. Reilly M.D. M. D. or other
Address: Harford Mem. Hosp. Date signed: 7/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

07070

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Rural Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hopkins Corner
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Reba J. Stine

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Curtis E. Stine

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): June 27 - 1912

8. AGE: Years: 36 Months: 0 Days: 20 If less than one day: ..... hrs. ..... min.

9. Birthplace: Churchville Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Frank E. Cullum
13. Birthplace: Harford Co.

MOTHER
14. Maiden name: Catherine L. Morris
15. Birthplace: Harford Co. Md

16. Informant: Mrs. Curtis E. Stine

Address: Havre de Grace Md. R-D #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1946 (month) (day) (year)

Cemetery or crematory: Smith Chapel

Location: Churchville Harford Co.

18. Funeral director: Henry Tarring Sons

Address: Aberdeen Md.

19. July 18 1946 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1946, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 9, 1946, to July 16 1946 and that I last saw h.e.r. alive on July 16 1946

Immediate cause of death: CARCINOMA OF CERVIX — DURATION: 1 YEAR

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: CARCINOMA OF CERVIX

Date of op. 2/4/46 5/4/46

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert A. Barthel M.D.
M. D. or other

Address: Forest Hill, Maryland Date signed 7/18/46

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

017071

Reg. Dist. No. 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen Proving Ground

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred: Bathing Beach, Aberdeen Proving Ground

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County: Ross

City or town: Chillicothe

(If outside city or town limits, write RURAL and give nearest town)

Street No. R #5 Rural

(If rural, give LOCATION)

2.(a) If veteran, name war: soldier at time of death

3.(a) FULL NAME Raymond D. Seword

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 28 Oct 1928

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
17	9	7		

9. Birthplace: Chillicothe Ross County Ohio (Town, county, and state)

10. Usual occupation: soldier

11. Industry or business

FATHER — 12. Name: Ora Alfred Seword

13. Birthplace: Rushtown Scioto Co. Ohio.

MOTHER — 14. Maiden name: Hazel E. Evans

15. Birthplace: Wamsleyville, Adams Co. Ohio

16. Informant: U.S. Army Records

Address: Aberdeen Proving ground Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof July 22 1946 (month) (day) (year)

Cemetery or crematory: Boyer Funeral Home

Location: Waverly, Ohio

18. Funeral director: Howard K. McCormack

Address: Abingdon Maryland

19. July 25 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 July 1946, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: accidental drowning	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 21 July 46

Where did injury occur? Aberdeen Proving Ground Harford Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Edwin W. Amyes M.D. 1st Lt M.C. M. D. or other

Address: Harford Co. Hosp. Aberdeen Proving Ground, Md. Date signed 21 July 46

OUTSIDE CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

171172

Reg. Dist. No. 125

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Havre De GRACE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ruth Thelma TESTERMAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16 1922

8. AGE: Years 24 | Months — | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Grayson Co., Va.
(Town, county, and state)
10. Usual occupation Shoe Worker
11. Industry or business Bata Shoe Factory

FATHER
12. Name Eugene Testerman
13. Birthplace Grayson Co. Va.

MOTHER
14. Maiden name Minnie M. Barner
15. Birthplace Grayson Co. Va.

16. Informant Mr. Eugene Testerman
Address Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28 1946 (month) (day) (year)
Cemetery or crematory Dublin Cemetery
Location Harford Co. Maryland

18. Funeral director H. S. Bailey
Address Darlington, Md.

19. July 26 46 (Date rec'd by registrar) A. E. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1946 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1946 to July 25 1946 and that I last saw him alive on July 25 1946

Immediate cause of death	DURATION
ACUTE HYDCARDITIS	5 days
~~Fibrosis~~ INITIATED	
Due to Bg LOBAR PNEUMONIA	
Due to	
Due to	
Other conditions One Lung (Rt.) removed 10 yrs ago for Bronchiectasis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill, Md Date signed 7/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07073

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? about 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 Revolution St.,
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME James W. Thomas

3.(b) Social Security Number 705-09-7396

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Glennetta O. Noel
6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) July 21st 1901

8. AGE: Years 45 Months — Days 5 If less than one day hrs. min.

9. Birthplace Washington Co., Va.
(Town, county, and state)

10. Usual occupation Railroad Employee

11. Industry or business

FATHER
12. Name Andrew E. Thomas
13. Birthplace Washington Co. Va.

MOTHER
14. Maiden name Francis Wyatt
15. Birthplace Washington Co. Va.

16. Informant Mrs. Glennetta O. Thomas
Address 604 Revolution St. Havre de Grace

17. Burial Date thereof July 29 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Henry Tarring & Sons
Address Aberdeen, Md.

19. July 27 1946 A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 to July 26 1946
and that I last saw h.. alive on July 26 1946

Immediate cause of death Acute Myocarditis — DURATION 2 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dudley Phillips MD M. D. or other
Address Harford Mem. Hosp. Date signed 7/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

705.09-739c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5+6)

CERTIFICATE OF DEATH

* 07074

Reg. Dist. No. 185

WITHIN CORPORATE LIMITS OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address (where death occurred): 311 Bourbon St.

How long in hospital or institution? 75 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 311 Bourbon St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Ulysses Grant Way

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rebecca Jane Way

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1863

8. AGE:

Years	Months	Days	If less than one day
82	8	20	— hrs. — min.

9. Birthplace: Cecil Co. Md. (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: Fishing & Gunning & Capt.

FATHER 12. Name: Samuel T. Way

13. Birthplace: Penn.

MOTHER 14. Maiden name: Leah Shanks

15. Birthplace: Penn.

16. Informant: Miss Reta B. Way

Address: 311 Bourbon St. Havredegrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 20 1946 (month) (day) (year)

Cemetery or crematory: Angel Hill Cem.

Location: Havre de Grace, Md.

18. Funeral director: T. Madison Mitchell

Address: Havre de Grace, Md.

19. July 20 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1946 at 5 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 3 1944 to July 17 1946 and that I last saw him alive on July 15 1946

Immediate cause of death	DURATION
Carcinoma of	
Due to Prostate	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. L. Lewis M.D. M. D. or other

Address: Havre de Grace Md. Date signed: 7-20-46